

# Springfield Family Chiropractic PC

Name \_\_\_\_\_

7 E. Woodland Ave. ♦ Springfield, PA 19064 ♦ 610-544-6336 fax: 610-544-7059

## Auto Injury Patient Information

Today's Date:	/ /
Date of Accident:	/ /

### 1. Personal Information:

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Street Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Dominant Hand: Right  Left  Both

### 2. Insurance Information

Were you the driver: Yes  No

**Part A:** (If same as above, skip to Part B)

Insured's Name: \_\_\_\_\_

Insured's Address: \_\_\_\_\_ Insured's Phone: \_\_\_\_\_

Insured's City, State, Zip: \_\_\_\_\_

#### Part B:

Insurance Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Accident Claim #: \_\_\_\_\_

Insurance Company Phone #: ( ) - \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_

Adjuster's Name/Phone #: \_\_\_\_\_

### 3. Attorney Information Check here if N/A

Attorney's Name: \_\_\_\_\_ Attorney's Phone: \_\_\_\_\_

Attorney's Street Address: \_\_\_\_\_

Attorney's City/State/Zip: \_\_\_\_\_ Contact Name: \_\_\_\_\_

### Additional Notes:

## Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

**1. Your vehicle type    2. Your position in vehicle    3. What was your vehicle doing at the time of the accident?**

<input type="checkbox"/> Car <input type="checkbox"/> Station Wagon <input type="checkbox"/> Van <input type="checkbox"/> Pickup Truck <input type="checkbox"/> Large Truck <input type="checkbox"/> Bus Other _____	<input type="checkbox"/> Driver <input type="checkbox"/> Front Passenger <input type="checkbox"/> Left Rear Passenger <input type="checkbox"/> Right Rear Passenger Other _____	<input type="checkbox"/> Stopped at intersection <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Stopped at light <input type="checkbox"/> Making a right turn <input type="checkbox"/> Making a left turn <input type="checkbox"/> Parking <input type="checkbox"/> Proceeding along <input type="checkbox"/> Slowing down <input type="checkbox"/> Accelerating Other _____
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**4. Time/Speed/Damage    5. Details of Accident    6. Road conditions**

Time of accident _____ Your vehicle's speed: _____ mph Their vehicle's speed: _____ mph  <b>Damage to your vehicle</b> <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled	<b>Visibility at time of accident</b> <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good  <b>Who hit who/what?</b> <input type="checkbox"/> You hit other vehicle <input type="checkbox"/> Other vehicle hit you <b>You hit...(object)</b> _____	<b>Road conditions at time of accident</b> <input type="checkbox"/> Icy <input type="checkbox"/> Wet <input type="checkbox"/> Sandy <input type="checkbox"/> Dark <input type="checkbox"/> Clean and dry  <b>Point of impact</b> <input type="checkbox"/> Head-On <input type="checkbox"/> Left Front <input type="checkbox"/> Right Front <input type="checkbox"/> Rear-End <input type="checkbox"/> Left Rear <input type="checkbox"/> Right Rear
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**7. Body Position, etc.**

Did you see the accident coming?    Yes <input type="checkbox"/> <input type="checkbox"/> No Were you braced for the impact?    Yes <input type="checkbox"/> <input type="checkbox"/> No Did you have a seat belt on?    Yes <input type="checkbox"/> <input type="checkbox"/> No Did you have a shoulder harness on?    Yes <input type="checkbox"/> <input type="checkbox"/> No	<b>Does your vehicle have headrests?</b> Yes <input type="checkbox"/> <input type="checkbox"/> No <b>What was the position of your headrest at the time of the impact:</b> <input type="checkbox"/> Even with top of head <input type="checkbox"/> Even with bottom of head <input type="checkbox"/> Middle of neck <b>What was the direction of your head at the time of impact:</b> <input type="checkbox"/> Facing straight forward <input type="checkbox"/> Turned to the right <input type="checkbox"/> Turned to the left	Did driver side air bags deploy? Yes <input type="checkbox"/> <input type="checkbox"/> No    Did passenger side air bags deploy? Yes <input type="checkbox"/> <input type="checkbox"/> No    Did side airbags deploy? Yes <input type="checkbox"/> <input type="checkbox"/> No
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**8. Additional accident information**

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

**9. During the accident:**

Did your body strike inside of your vehicle? Yes   No  
 If yes, describe: \_\_\_\_\_  
 Did you lose consciousness during the injury? Yes   No  
 If yes, for how long? \_\_\_\_\_  
 Your vehicle's estimated damage? \_\_\_\_\_  
**Damage to their vehicle:**  Mild    Moderate    Totaled  
 Did police show up at the scene?    Yes   No  
 Was an accident report filled out?    Yes   No

**10. After the accident:**

**Check off your symptoms following the accident:**  
 Headache    Dizziness    Mid back pain    Cold hands  
 Neck pain    Nausea    Low back pain    Cold feet  
 Neck stiffness    Confusion    Nervousness    Diarrhea  
 Fainting    Fatigue    Loss of taste    Depression  
 Ringing in ears    Tension    Toe numbness    Anxious  
 Loss of smell    Irritability    Constipation    Chest Pain  
 Pain behind eyes    Shortness of breath    Sleeping problems  
 Others: \_\_\_\_\_

**11. Emergency Room?**

**Where did you go after the accident?**  
 Home    Work    Hospital ER    Private Doctor  
**How did you get there?**  
 Self    Somebody else    Ambulance    Police  
**X-rays done?** Yes   No   **Lab work?** Yes   No  
 Body parts X-rayed? \_\_\_\_\_  
 What lab work? \_\_\_\_\_  
 The X-rays revealed: \_\_\_\_\_  
**Treatments:**  Cervical Collar    Ice   **Other:** \_\_\_\_\_  
 Medications: \_\_\_\_\_  
 Follow-up instructions: \_\_\_\_\_

**12. Treatment History:**

**Fill in other doctor(s) seen prior to your first visit to this office.**  
**1. Dr.** \_\_\_\_\_ First visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Specialty: \_\_\_\_\_ X-rays done? Yes   No  
 Types of treatments received: \_\_\_\_\_  
 How many treatments received? \_\_\_\_ Currently treating? Yes No  
 Did treatments benefit you? Yes   No  
 Last visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**2. Dr.** \_\_\_\_\_ First visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Types of treatments received: \_\_\_\_\_  
 How many treatments received? \_\_\_\_ Currently treating: Yes No  
 Did treatments benefit you? Yes   No  
 Last visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty. **1** = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it all, because of the pain". **NOTE: Only fill in areas affected.**

<b>Difficulties with Self Care and Personal Hygiene Activities</b>					
Bathing _____	Drying hair _____	Brushing teeth _____	Putting on shoes _____	Preparing meals _____	Taking out trash _____
Showering _____	Combing hair _____	Making bed _____	Tying shoes _____	Eating _____	Doing laundry _____
Washing hair _____	Washing face _____	Putting on shirt _____	Putting on pants _____	Cleaning dishes _____	Going to toilet _____
<b>Difficulties with Physical Activities</b>					
Standing _____	Walking _____	Kneeling _____	Bending back _____	Twisting left _____	Leaning back _____
Sitting _____	Stooping _____	Reaching _____	Bending left _____	Twisting right _____	Leaning left _____
Reclining _____	Squatting _____	Bending forward _____	Bending right _____	Leaning forward _____	Leaning right _____
Standing for long periods _____	Sitting for long periods _____	Walking for long periods _____	Kneeling for long periods _____		
<b>Difficulties with Functional Activities</b>					
Carrying small objects _____	Lifting weights off floor _____	Pushing things while seated _____	Exercising upper body _____		
Carrying large objects _____	Lifting weights off table _____	Pushing things while standing _____	Exercising lower body _____		
Carrying brief case _____	Climbing stairs _____	Pulling things while seated _____	Exercising arms _____		
Carrying large purse _____	Climbing inclines _____	Pulling things while standing _____	Exercising legs _____		
<b>Difficulties with Social and Recreational Activities</b>					
Bowling _____	Jogging _____	Swimming _____	Ice Skating _____	Competitive Sports _____	Dating _____
Golfing _____	Dancing _____	Skiing _____	Roller Skating _____	Hobbies _____	Dining out _____
<b>Difficulties with Traveling</b>					
Driving a motor vehicle _____	Riding as a passenger in a motor vehicle _____	Riding as a passenger on a train _____			
Driving for long periods of time _____	Riding as a passenger on an airplane _____	Riding as a passenger for long periods _____			

Use the following 1 to 5 scale to describe the difficulties below:

**1** = This area is not affected by my condition, **2** = This area is slightly affected by my condition, **3** = My condition moderately restricts my ability in this area, **4** = My condition seriously limits my ability in this area, **5** = My condition prevents me from using this ability

<b>Difficulties with Different Forms of Communication</b>						
Concentrating _____	Hearing _____	Listening _____	Speaking _____	Reading _____	Writing _____	Using a keyboard _____
<b>Difficulties with the Senses</b>						
Seeing _____	Hearing _____	Sense of touch _____	Sense of taste _____	Sense of smell _____		
<b>Difficulties with Hand Functions</b>						
Grasping _____	Holding _____	Pinching _____	Percussive movements _____	Sensory discrimination _____		
<b>Difficulties with Sleep and Sexual Function</b>						
Being able to have normal, restful nights sleep _____	Being able to participate in desired sexual activity _____					

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

### Prior Symptom History

<p><b>Prior Similar Symptoms</b></p> <p><input type="checkbox"/> I have NOT had prior symptoms similar to my current complaints.</p> <p><input type="checkbox"/> My current complaints DID exist before, but had not been bothering me.</p> <p><input type="checkbox"/> My current complaints ALREADY existed and were worsened.</p>	<p><b>Has your History Contributed to your Current Symptoms?</b></p> <p><input type="checkbox"/> My history HAS contributed to my current symptoms.</p> <p><input type="checkbox"/> My history HAS NOT contributed to my current symptoms.</p> <p><input type="checkbox"/> I'm NOT SURE if my history has contributed to my current symptoms.</p>
<p>My most recent prior similar symptoms (if applicable) occurred _____ <input type="checkbox"/> months ago / <input type="checkbox"/> years ago OR on Date: ____/____/____</p>	

Write in below any other Prior Symptom History, not covered above:

Name \_\_\_\_\_

Date \_\_\_\_\_

**Description of Symptoms** (Describe your symptoms in the sections below, in the order of severity, if possible.)

**Current Symptom:** (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section)

<b>1. Check only one body location below</b> <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other locations: _____			<b>2. Types of pain</b> <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting <b>Other types of pain:</b> _____																																																																
<b>3. Pain Frequency</b> <input type="checkbox"/> Upto 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time		<b>6. Actions affecting this pain</b> <table border="1"> <thead> <tr> <th></th> <th>Brings On</th> <th>Aggravates</th> <th>Relieves</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> In the A.M.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> In the P.M.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending forward</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending back</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending left</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending right</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Twisting left</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Twisting right</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Coughing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Sneezing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Straining</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Standing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Sitting</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Lifting</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><b>Other Actions:</b></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>			Brings On	Aggravates	Relieves	<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other Actions:</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**Current Symptom:** (Please check off the boxes below to describe your next symptom).

<b>1. Check only one body location below</b> <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other locations: _____			<b>2. Types of pain</b> <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting <b>Other types of pain:</b> _____																																																																
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Name \_\_\_\_\_

Date \_\_\_\_\_

**Description of Symptoms** (Describe your symptoms in the sections below, in the order of severity, if possible.)

**Current Symptom:** (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section)

<b>1. Check only one body location below</b> <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other locations: _____			<b>2. Types of pain</b> <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting Other types of pain: _____																																																																
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<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																

**Current Symptom:** (Please check off the boxes below to describe your 3rd symptom).

<b>1. Check only one body location below</b> <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other locations: _____			<b>2. Types of pain</b> <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting Other types of pain: _____																																																																
<b>3. Pain Frequency</b> <input type="checkbox"/> Upto 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time		<b>6. Actions affecting this pain</b> <table border="1"> <tr> <th></th> <th>Brings On</th> <th>Aggravates</th> <th>Relieves</th> </tr> <tr> <td><input type="checkbox"/> In the A.M.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> In the P.M.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Bending forward</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Bending back</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Bending left</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Bending right</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Twisting left</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Twisting right</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Coughing</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Sneezing</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Straining</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Standing</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Sitting</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Lifting</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Other Actions:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>			Brings On	Aggravates	Relieves	<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<b>4. Pain Intensity (How it affects your daily activities)</b> <input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects <input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities		<b>5. Does this pain radiate into other body parts?</b> <table border="1"> <tr> <th></th> <th>Left</th> <th>Right</th> <th>Both</th> </tr> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Arm</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Leg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Foot</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> Other locations of radiation: _____			Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
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## Health History

**Date of Last:** Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT- Scan, Bone Scan \_\_\_\_\_

**Have you ever had any of the following:**

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Pressure H	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Pressure L	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insomnia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Memory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors/ Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Menstrual Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical		Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nightsweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies _____	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pins & Needles	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Are you pregnant?  Yes  No  N/A

Is there a family history of ...  Heart disease  Arthritis  Cancer  Diabetes

<p><b>Exercise</b></p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p><b>Work Activity</b></p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light labor <input type="checkbox"/> Heavy labor	<p><b>Habits</b></p> <input type="checkbox"/> Smoking _____ packs/day <input type="checkbox"/> Alcohol _____ drinks/day <input type="checkbox"/> Coffee/Caffeine drinks _____ cups or cans/day <input type="checkbox"/> High stress level reason: _____
---	---	--

**Injuries you have had:**

<input type="checkbox"/> Falls	Description/Date
<input type="checkbox"/> Head injuries	_____
<input type="checkbox"/> Broken bones	_____
<input type="checkbox"/> Dislocations	_____
<input type="checkbox"/> Surgeries	_____

<b>Current Medications</b>	<b>Vitamins/Herbs/Minerals</b>

## Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation, nor do we offer advice regarding treatment prescribed by others. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

By signing below, I indicate that I have read and fully understand the above statements.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **Authorization for Assignment**

In consideration of Springfield Family Chiropractic undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute any action in my name as you see fit and further authorize you to compromise, settle or otherwise receive any claim as you see fit. However it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amount you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this Commonwealth of Pennsylvania.
5. I further agree that this Authorization for Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effect until revoked by both parties.

---

Patient/Insured signature

Date

### **Authorization for Records Release**

To Springfield Family Chiropractic, I hereby authorize you to release to any insurance company, attorney or adjuster any information including the diagnosis and records of treatment or examination rendered to me for any and/or all the care I receive.

---

Patient/Insured signature

Date

Name \_\_\_\_\_

## **Doctor's Lien and Instructions to Counsel**

I, the undersigned, understand that all past, present and future bills incurred at Springfield Family Chiropractic, P.C., are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at Springfield Family Chiropractic, P.C..

In consideration for Springfield Family Chiropractic, P.C. having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/ injury/ illness, without financial hardship, I give you a loan on any settlement, clear judgment, verdict or result of accident/ injury/ illness and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claim or judgment related to this accident/ injury/ illness.

I also understand that if the settlement does not cover my entire bill from Springfield Family Chiropractic, P.C., I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim or judgment which I may eventually recover.

Furthermore in consideration for Springfield family Chiropractic, P.C. refraining from attempting to collect immediate payment for services rendered for my accident/ injury/ illness, I do hereby waive and toll any applicable status of limitations on the collection of my account until I notify Springfield Family Chiropractic, P.C. of the conclusion of my efforts to obtain a settlement or judgment through the assistance of my attorney and for a period of three (3) months thereafter.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## **Instructions to Counsel**

I do hereby irrevocably instruct you, my Attorney, named below, to pay Springfield Family Chiropractic, P.C., in full for services to me for my accident/ injury/ illness from any proceed or settlement, claim or judgment regarding my accident/ injury/ illness. You are to pay Springfield Family Chiropractic, P.C. prior to distributing any proceeds to me and I instruct you not to attempt to reduce by means of negotiation my doctor's bill for the services that have been provided to me for the accident/ injury/ illness which I have agreed to pay in full.

\_\_\_\_\_  
Firm Name

\_\_\_\_\_  
Attorney Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# Springfield Family Chiropractic PC

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### **Key Issues**

#### Uses and Disclosures:

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

#### Our legal duty:

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

#### Complaints:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

Jeanne Miller  
7 E. Woodland Ave.  
Springfield, PA 19064  
610-544-6336

### **Further Details**

#### 1. Uses and Disclosures of Protected Health Information

Following are examples of the types of uses and disclosures of your protected health care information that the provider is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, in activities related to obtaining payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health insurance company or governmental plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support our business activities. For example, when we review employee performance, we may need to look at what an employee has documented in your medical record.

Business Associates: We may share your protected health information with a third party 'business associate' that performs various activities (e.g., billing, transcription services). Whenever an arrangement between us and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Marketing: We may use or disclose certain health information in the course of providing you with information about treatment alternatives, health-related services, or fund-raising. You may contact us to request that these materials not be sent to you.

Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing.

Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to object. If you are not present or able to object, then your provider may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.

Emergencies: In an emergency treatment situation, we will provide you a Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

Communication Barriers: We may use and disclose your protected health information if we have attempted to obtain acknowledgement from you of our Notice of Privacy Practices but have been unable to do so due to substantial communication barriers and we determine, using professional judgment, that you would agree.

Without Opportunity to Object: We may use or disclose your protected health information in the following situations without your authorization or opportunity to object:

*Public Health:* for public health purposes to a public health authority or to a person who is at risk of contracting or spreading your disease.

*Health Oversight:* to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

*Abuse or Neglect:* to an appropriate authority to report child abuse or neglect, if we believe that you have been a victim of abuse, neglect, or domestic violence.

*Legal Proceedings:* in the course of legal proceedings.

*Law Enforcement:* for law enforcement purposes, such as pertaining to victims of a crime or to prevent a crime.

*Coroners, Funeral Directors, and Organ Donation:* for the coroner, medical examiner, or funeral director to perform duties authorized by law and for organ donation purposes.

*Research:* to researchers when their research has been approved by an Institutional Review Board or Privacy Board.

*Soldiers, Inmates, and National Security:* to military supervisors of Armed Forces personnel or to custodians of inmates, as necessary. Preserving national security may also necessitate disclosure of protected health information.

*Workers' Compensation:* to comply with workers' compensation laws.

*Compliance:* to the Department of Health and Human Services to investigate our compliance. In general, we may use or disclose your protected health information as required by law and limited to the relevant requirements of the law.

## **2. Your Rights**

You have the right to:

- inspect and copy your protected health information.
- request a restriction of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for treatment, payment or healthcare operations. You may also request that information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, but if we do agree, then we must act accordingly.
- request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.
- ask us to amend your protected health information. You may request an amendment of protected health information about you. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and your medical record will note the disputed information.
- receive an accounting of certain disclosures we may have made. This right applies to disclosures for purposes other than treatment, payment or healthcare operations. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.
- obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

# Acknowledgement of Receipt of Notice of Privacy Practices

Please print your name, sign and date this form to acknowledge that you have received our Notice of Privacy Practices. We strive to protect your personal information and offer professional service at Springfield Family Chiropractic. Please let us know if you have any questions or concerns about this notice.

Printed name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## NECK PAIN DISABILITY INDEX QUESTIONNAIRE

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><b>SECTION 1 - Pain Intensity</b></p> <p>A I have no pain at the moment.            B The pain is very mild at the moment.            C The pain is moderate at the moment.            D The pain is fairly severe at the moment.            E The pain is very severe at the moment.            F The pain is the worst imaginable at the moment.</p>	<p><b>SECTION 6 - Concentration</b></p> <p>A I can concentrate fully when I want to with no difficulty.            B I can concentrate fully when I want to with slight difficulty.            C I have a fair degree of difficulty in concentrating when I want to.            D I have a lot of difficulty in concentrating when I want to.            E I have a great deal of difficulty in concentrating when I want to.            F I cannot concentrate at all.</p>
<p><b>SECTION 2 - Personal Care (Washing, Dressing, etc.)</b></p> <p>A I can look after myself normally without causing extra pain.            B I can look after myself normally, but it causes extra pain.            C It is painful to look after myself and I am slow and careful.            D I need some help, but manage most of my personal care.            E I need help every day in most aspects of self care.            F I do not get dressed, I wash with difficulty and stay in bed.</p>	<p><b>SECTION 7 - Work</b></p> <p>A I can do as much work as I want to.            B I can only do my usual work, but no more.            C I can do most of my usual work, but no more.            D I cannot do my usual work.            E I can hardly do any work at all.            F I cannot do any work at all.</p>
<p><b>SECTION 3 - Lifting</b></p> <p>A I can lift heavy weights without extra pain.            B I can lift heavy weights, but it gives extra pain.            C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.            D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.            E I can lift very light weights.            F I cannot lift or carry anything at all.</p>	<p><b>SECTION 8 - Driving</b></p> <p>A I can drive my car without any neck pain.            B I can drive my car as long as I want with slight pain in my neck.            C I can drive my car as long as I want with moderate pain in my neck.            D I cannot drive my car as long as I want because of moderate pain in my neck.            E I can hardly drive at all because of severe pain in my neck.            F I cannot drive my car at all.</p>
<p><b>SECTION 4 - Reading</b></p> <p>A I can read as much as I want to with no pain in my neck.            B I can read as much as I want to with slight pain in my neck.            C I can read as much as I want to with moderate pain in my neck.            D I cannot read as much as I want because of moderate pain in my neck.            E I cannot read as much as I want because of severe pain in my neck.            F I cannot read at all.</p>	<p><b>SECTION 9 - Sleeping</b></p> <p>A I have no trouble sleeping.            B My sleep is slightly disturbed (less than 1 hour sleepless).            C My sleep is mildly disturbed (1-2 hours sleepless).            D My sleep is moderately disturbed (2-3 hours sleepless).            E My sleep is greatly disturbed (3-5 hours sleepless).            F My sleep is completely disturbed (5-7 hours)</p>
<p><b>SECTION 5 - Headaches</b></p> <p>A I have no headaches at all.            B I have slight headaches which come infrequently.            C I have moderate headaches which come infrequently.            D I have moderate headaches which come frequently.            E I have severe headaches which come frequently.            F I have headaches almost all the time.</p>	<p><b>SECTION 10 - Recreation</b></p> <p>A I am able to engage in all of my recreational activities with no neck pain at all.            B I am able to engage in all of my recreational activities with some pain in my neck.            C I am able to engage in most, but not all of my recreational activities because of pain in my neck.            D I am able to engage in a few of my recreational activities because of pain in my neck.            E I can hardly do any recreational activities because of pain in my neck.            F I cannot do any recreational activities at all.</p>

**COMMENTS:** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SCORE:** \_\_\_\_\_ /50 = \_\_\_\_\_ % POINTS

**REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE**

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><b>SECTION 1 - Pain Intensity</b></p> <p>A The pain comes and goes and is very mild.          B The pain is mild and does not vary much.          C The pain comes and goes and is moderate.          D The pain is moderate and does not vary much.          E The pain comes and goes and is severe.          F The pain is severe and does not vary much.</p>	<p><b>SECTION 6 - Standing</b></p> <p>A I can stand as long as I want without pain.          B I have some pain while standing, but it does not increase with time.          C I cannot stand for longer than one hour without increasing pain.          D I cannot stand for longer than 1/2 hour without increasing pain.          E I cannot stand for longer than ten minute without increasing pain.          F I avoid standing, because it increases the pain straight away.</p>
<p><b>SECTION 2 - Personal Care</b></p> <p>A I would not have to change my way of washing or dressing in order to avoid pain.          B I do not normally change my way of washing or dressing even though it causes some pain.          C Washing and dressing increases the pain, but I manage not to change my way of doing it.          D Washing and dressing increases the pain and I find it necessary to change my way of doing it.          E Because of the pain, I am unable to do some washing and dressing without help.          F Because of the pain, I am unable to do any washing or dressing without help.</p>	<p><b>SECTION 7 - Sleeping</b></p> <p>A I get no pain in bed.          B I get pain in bed, but it does not prevent me from sleeping well.          C Because of pain, my normal night's sleep is reduced by less than one than one quarter.          D Because of pain, my normal night's sleep is reduced by less than one-half.          E Because of pain, my normal night's sleep is reduced by less than three-quarters.          F Pain prevents me from sleeping at all.</p>
<p><b>SECTION 3 - Lifting</b></p> <p>A I can lift heavy weights without extra pain.          B I can lift heavy weights, but it causes extra pain.          C Pain prevents me from lifting heavy weights off the floor.          D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.          E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.          F I can only lift very light weights, at the most.</p>	<p><b>SECTION 8 - Social Life</b></p> <p>A My social life is normal and gives me no pain.          B My social life is normal, but increases the degree of my pain.          C Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.          D Pain has restricted my social life and I do not go out very often.          E Pain has restricted my social life to my home.          F I have hardly any social life because of the pain.</p>
<p><b>SECTION 4 - Walking</b></p> <p>A Pain does not prevent me from walking any distance.          B Pain prevents me from walking more than one mile.          C Pain prevents me from walking more than 1/2 mile.          D Pain prevents me from walking more than 1/4 mile.          E I can only walk while using a cane or on crutches.          F I am in bed most of the time and have to crawl to the toilet.</p>	<p><b>SECTION 9 - Traveling</b></p> <p>A I get no pain while traveling.          B I get some pain while traveling, but none of my usual forms of travel make it any worse.          C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.          D I get extra pain while traveling which compels me to seek alternative forms of travel.          E Pain restricts all forms of travel.          F Pain prevents all forms of travel except that done lying down.</p>
<p><b>SECTION 5 - Sitting</b></p> <p>A I can sit in any chair as long as I like without pain.          B I can only sit in my favorite chair as long as I like.          C Pain prevents me from sitting more than one hour.          D Pain prevents me from sitting more than 1/2 hour.          E Pain prevents me from sitting more than ten minutes.          F Pain prevents me from sitting at all.</p>	<p><b>SECTION 10 - Changing Degree of Pain</b></p> <p>A My pain is rapidly getting better.          B My pain fluctuates, but overall is definitely getting better.          C My pain seems to be getting better, but improvement is slow at present.          D My pain is neither getting better nor worse.          E My pain is gradually worsening.          F My pain is rapidly worsening.</p>

**COMMENTS:** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SCORE:** \_\_\_\_\_ /50 = \_\_\_\_\_ % POINTS